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When You Can't Breathe, Nothing Else Matters®

AMERICAN LUNG ASSOCIATION® of Washington

June 20, 2002

Doug Porter, Assistant Secretary
Medical Assistance Administration
ATTN: Medicaid & SCHIP Reform Waiver
Dept. of Social and Health Services
P.O. Box 45500
Olympia, WA 98504-5500

Dear Mr. Porter:

Thank you for this opportunity to comment on the proposed DSHS waiver regarding Medicaid and the State Children's Health Insurance Program. As an organization whose mission is to protect and promote the lung health of Washington's citizens, especially those who have lung disease, the American Lung Association of Washington has some serious concerns about the potential impact of this proposal on the access to care by low-income persons with lung disease.

We recognize that health care costs are a major driving force behind our current state budget crisis, with Medicaid costs rising precipitously in the last several years. Despite these increasing costs, people are already having significant difficulty accessing Medicaid services, with many providers across the state refusing to see Medicaid patients across the state because they are under-compensated for these services.

We do not feel that decreasing access to services for low-income persons, either by rationing benefits, eligibility, or by cost, are appropriate ways to deal with this situation. It will simply exacerbate the existing problems, and make the hole that much deeper to dig out of. In addition, once such cutbacks are made, it is highly unlikely that they will be restored in the future.

About 11% of Washington's citizens already have no health insurance, public or private, and the 2000 Census indicated that Washington is one of just a handful of states with the problem of lack of insurance coverage increasing in recent years. Medicaid recipients are the poorest citizens in our state, with individuals making less than $8,590 per year, and a family of four making $17,650 per year(2001).

We understand that there are several ways that you are considering making changes to the Medicaid program, and we would like to comment on each of those before making recommendations on alternatives to these approaches.

A co-payment of $5 for brand-name drugs when equivalent, lower-cost drugs are available seems appropriate, given that there would be no barrier to receiving the needed medications because of generic or other equivalent drugs being available.

Likewise, a $10 co-payment for non-emergency use of emergency rooms also seems appropriate, as long as the local community actually has adequate resources of providers to serve the Medicaid population in a timely fashion. If there is not an adequate network of providers available to serve Medicaid enrollees, they are left with no choice but to use emergency rooms as their primary care site. In addition, a "prudent layperson" standard should be applied to emergency room use, as is currently included for private health insurance plans under RCW 48.43.093.

We also agree that any reform of Medicaid must allow Washington State to use its unspent SCHIP dollars to help provide medical coverage through the Basic Health program to uninsured childless adults and parents of Medicaid children. In fact, gaining this revenue that belongs to Washington should be the primary focus of any waiver request.

Premiums are the least appropriate fashion for controlling costs under Medicaid. The net effect of premiums for impoverished Medicaid enrollees would be to make Medicaid unaffordable to the poorest citizens of our state, and presumably the method for controlling costs would be by dropping coverage for those who were unable to pay the premiums. This would devastate access to health care services for these poorest citizens of the state, and would be the most counter-productive method possible for controlling Medicaid costs. These persons would be reduced to using the emergency rooms for uncompensated care, the cost of which would be borne by providers and potentially passed on to other consumers.

We also do not believe that Medicaid benefits should be diluted to the extent of the state's Basic Health Plan (BHP). The benefits in the BHP are extremely limited, and often fail to meet the needs of low-income citizens.

Medicaid enrollment in optional programs should not be arbitrarily capped based on financial considerations. Though there are serious budget constraints for the state, and such a move would allegedly be intended to protect current enrollees, programs that directly impact life or death decisions for our state's poorest citizens are the absolute worst place to make such a unilateral cutoff.

There are ~~five~~ four major ways at which we would recommend DSHS look for managing the increasing costs in the Medicaid program:

First, reduce the cost of prescription drugs to the state and to Washington citizens by passing legislation to establish a preferred drug list. Such legislation was passed last year in Oregon, and was proposed here in Washington this year. This would dramatically reduce the cost of prescription drugs, without limiting enrollment, benefits, affordability, or access for the low-income citizens Medicaid is supposed to serve.

Second, gain cost savings through administrative efficiencies, consolidated purchasing, and standardization of public plans. Medicaid, BHP, and the Public Employee Benefits Board all contract with private health plans through a bidding process for coverage of their respective populations, yet the bidding process, benefits, cost sharing, and administration of these programs are very different. The state could save considerable money by consolidating this administration and benefit design into a single program, with cost sharing appropriate to the income of the populations. At the same time, the state could save itself and everyone else in the marketplace significant amounts of money by standardizing the current dizzying array of requirements, forms, preauthorizations, postauthorizations, case managers, and utilization review in each system and each health plan.

Third, recognize that we are in an economic time when the need for these services is greatest – people are being laid off, employers are decreasing or eliminating private benefit plans, and those private benefit plans for individuals are unaffordable. The state needs to do more, not less, to make sure that there is a safety net. People are on Medicaid either because they are so poor or so disabled (or both) that they need to be, and the total cost of services to the state is increasing because people's financial difficulties and medical needs are increasing, as are the types and costs of available treatments. People shouldn't be punished just because they are poor and sick, and funding should be sought for ensuring that we don't deny needed care to our state's most vulnerable citizens.

Fourth, utilize a rational, public decision-making process for the allocation of health care resources. Every health care system rations care to its consumers in some fashion – by affordability, by inconvenience, by benefit design, by access, by eligibility. This can either be done behind the scenes, through administrative means, or openly, through public means. The Oregon Health Plan has never been equaled in its inclusive public process, evaluating the costs and benefits of every benefit possible under Medicaid, ranking the services according to various factors in terms of cost-benefit to the state and consumers, and forcing the Legislature and the rest of government to make an explicit and open decision about what services will or will not be paid for by Medicaid. We should do likewise, rather than being asked, as we are now being asked, to make recommendations based on very vague choices and criteria.

Sincerely,

Nick Federici
Director of Government Relations